BlueCross BlueShield of Delaware
A CareFirst Company

Blue Cross Blue Shield of Delaware and CareFirst, Inc., are independent licensees of the Blue Cross and Blue Shield Association.

DISABLED CHILD APPLICATION

SEE CONDITIONS OF ELIGIBILITY ON THE REVERSE SIDE OF THIS APPLICATION.

Customer's Last Name (last name of parent)	First Name	Middle Initial

Customer's Address (street, box number, city, state, zip code)

Identification Number	Account Number	Telephone Number (include area code)

I REQUEST COVERAGE FOR THE DEPENDENT CHILD NAMED BELOW WHO IS TOTALLY DISABLED.

I understand and agree that:

1. Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Blue Cross Blue Shield of Delaware.
2. I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete.
3. I authorize any hospital, physician, professional review organization and any and all other providers of service to disclose and furnish to Blue Cross Blue Shield of Delaware and/ or its agents any and all records relating to the disabled child named in this application for whom services or benefits have been sought or to whom services or benefits have been provided, including a complete diagnosis and medical information.

Dependent's Last Name	First Name	Middle Initial

Dependent's Birthdate	Dependent's Relationship To Customer	Is dependent employed?
/ /	☐ Son ☐ Daughter ☐ Other ***(explain)***:	☐ **YES** ☐ **NO**

If **YES**, Name of Employer	Hours Worked Per Week	Rate of Pay
		$_____ per ☐ Hour ☐ Week ☐ Month ☐ Year

Type of Work Performed

Dependent's Address (If the same as customer's above, write "Same.")

Is this dependent currently enrolled with Blue Cross Blue Shield coverage under his or her own contract? ☐ **YES** ☐ **NO**	If **YES**, Give Contract Identification Number
Is this dependent covered by Medicare? ☐ **YES** ☐ **NO**	Medicare Claim Number
Medicare Part A Effective Date	Medicare Part B Effective Date

I HAVE READ AND DO AGREE TO THE ABOVE TERMS	Date
Signature of Customer: X	/ /

IMPORTANT!
Please Have Physician Complete The Reverse Side of This Application.

FOR BLUE CROSS BLUE SHIELD OF DELAWARE USE ONLY

Date Received	Primary	Secondary	Id Number	
Dependent Status Code	Request and Child Code		Dependent Name Status	
Approved	Temporarily Approved Through		Refused	Processed By
Date Processed	Date Received	Type Transaction	Primary Emp. #	Secondary Emp. #

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Physician's Name

Address

Telephone Number (include area code)

Is child incapable of self-support by reason of a mental/physical disability? ☐**YES** ☐**NO**	Date Child Became Incapable of Self-Support (month, day, year)	Date Child Was Last Treated (month, day, year)

Prognosis (Estimate In Months or Years)

Diagnosis of Condition Causing Disability (Indicate degree of severity.)

Is child confined in an institution? ☐ **YES** ☐ **NO**	If **YES**, Name of Institution

Signature of Physician:	**Please Print Name:**	Date / /

TO PARENTS

This application is being forwarded in answer to your request for coverage for an unmarried disabled dependent child.

Important point to know . . . A dependent disabled child should be added to his or her parent's coverage when he or she is first eligible.

Conditions which may make a son or daughter eligible to be covered as a dependent disabled child:

- The son or daughter must be unmarried.
- The son or daughter must have a physical or mental handicap which is so severe that he or she is unable to engage in gainful activity.
- The condition must be one that is expected to continue for a long and indefinite time. If it is a temporary handicap and can be expected to improve to the point he or she will be able to work, he or she is not eligible to be continued as a dependent under your Contract beyond the maximum age limit for dependent children as specified in the Contract.
- The condition of disability must have occurred prior to, and be continuous from, the maximum age limit for dependent children. For example, if the Contract states the maximum age as 19, then the disability must have occurred prior to age 19 for the disabled dependent child to be eligible.

In deciding whether the disability qualifies the child for coverage as a dependent "***Disabled Child***," Blue Cross Blue Shield of Delaware shall be the sole judge.

To apply for this benefit, it is necessary to complete the information on the reverse side of this application.

BLUE CROSS BLUE SHIELD OF DELAWARE
Underwriting 3-3-05
One Brandywine Gateway
P.O. Box 1991
Wilmington, DE 19899-1991
Visit our website: www.bcbsde.com

065-HH-001 (rev. 2/15/00)